BlueCHiP Coordinated Health Plan (Blue Cross & Blue Shield of Rhode Island) Formerly: BlueCHiP Coordinated Health Partners, Inc.

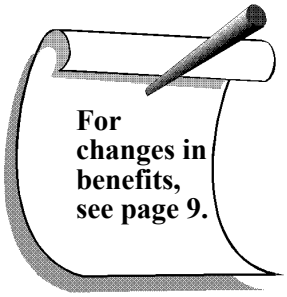
http://www.BCBSRI.com

2008

An Individual Practice Prepayment Plan with a Point of Service Product

Serving:

Rhode Island and portions of Southeastern Massachusetts



This Plan has an accreditation status of Excellent from NCQA.
See the 2008 Guide for more information on accreditation.

Enrollment in this plan is limited. You must live or work in our Geographic service area to enroll. See page 8 for requirements.

Enrollment code for this Plan:
DA1 Self Only
DA2 Self and Family

Authorized for distribution by the:

United States
Office of Personnel Management

Center for
Retirement and Insurance Services
http://www.opm.gov/insure

RI 73-489

Important Notice from Blue Cross & Blue Shield of Rhode Island About

Our Prescription Drug Coverage and Medicare

OPM has determined that BCBSRI's prescription drug coverage is, on average, comparable to Medicare Part D prescription drug coverage; thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefits. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and BCBSRI will coordinate benefits with Medicare.

Remember: If you are an annuitant and you terminate your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

- As long as you keep our coverage (or equivalent prescription drug coverage), you will not have to pay higher premiums for Medicare Part D prescription drug coverage if you decide to enroll later.
- If you lose or drop our coverage, you will have to pay a higher Part D premium if you go without equivalent prescription drug coverage for a period of 63 days or longer. If you enroll in Medicare Part D, your premium will increase 1 percent per month for each month you did not have equivalent prescription drug coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what most other people pay. You may also have to wait until the next open enrollment period to enroll in Medicare Part D.

Medicare's Low-Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 1-800-772-1213 (TTY 1-800-325-0778).

You can get more information about Medicare prescription drug coverage and the other coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help, or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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Introduction

This brochure describes the benefits of BlueCHiP Coordinated Health Plan (BlueCHiP) from Blue Cross & Blue Shield of Rhode Island under our contract (CS 2328) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The address for Blue Cross & Blue Shield of Rhode Island's administrative offices is:

Blue Cross & Blue Shield of Rhode Island

444 Westminster Street

Providence, RI 02903-3279

This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2007, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2008, and changes are summarized on page 9. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them responsive, accessible, and understandable to the public. For instance,

Except for necessary technical terms, we use common words. For instance, "you" means the enrollee or family member, "we" means *Blue Cross & Blue Shield of Rhode Island (BCBSRI).*

- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail OPM at fehbwebcomments@opm.gov. You may also write to OPM at the U.S. Office of Personnel Management, Insurance Services Programs, Program Planning & Evaluation Group, 1900 E Street, NW, Washington, DC 20415-3650.

Stop Health Care Fraud!

Fraud increases the cost of healthcare for everyone and increases your Federal Employees Health Benefits Program premium.

OPM's Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud – Here are some things that you can do to prevent fraud:

- Be wary of giving your plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using healthcare providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) statements that you receive from us.

- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

Call the provider and ask for an explanation. There may be an error.

If the provider does not resolve the matter, call us at (401) 274-3500 from within the State of Rhode Island or toll-free at 1-800-564-0888 from outside Rhode Island and explain the situation.

If we do not resolve the issue:

CALL THE HEALTHCARE FRAUD HOTLINE

(202) 418-3300

OR WRITE TO:

United States Office of Personnel Management

Office of the Inspector General Fraud Hotline

1900 E Street NW Room 6400

Washington, DC20415-1100

- Do not maintain as a family member on your policy:

Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or

Your child over age 22 (unless he/she is disabled and incapable of self-support).

- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

Preventing medical mistakes

An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That's about 3,230 preventable deaths in the FEHB Program a year. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. By asking questions, learning more and understanding your risks, you can improve the safety of your own healthcare, and that of your family members. Take these simple steps:

1. Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you ask questions and understand answers.

2. Keep and bring a list of all the medicines you take.

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines that you take, including non-prescription (over-the-counter) medicines.
- Tell them about any drug allergies you have.

- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient insert when you get your medicine. Ask the pharmacist about your medicine if it looks different than you expected.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures.
- Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.

4. Talk to your doctor about which hospital is best for your health needs.

- Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the healthcare you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital.

5. Make sure you understand what will happen if you need surgery.

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:

Exactly what will you be doing?

About how long will it take?

What will happen after surgery?

How can I expect to feel during recovery?

- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications you are taking.

Want more information on patient safety?

Ø www.ahrq.gov/path/beactive.htm. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality healthcare providers and improve the quality of care you receive.

Ø www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer healthcare for you and your family.

Ø www.talkaboutrx.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.

Ø www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.

Ø www.ahqa.org. The American Health Quality Association represents organizations and healthcare professionals working to improve patient safety.

Ø www.quic.gov/report. Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's healthcare delivery system.

Section 1 Facts about this Individual Practice Prepayment Plan

This Plan is an individual practice prepayment plan. We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your healthcare services. BCBSRI is solely responsible for the selection of these providers in your area. Contact us for a copy of their most recent provider directory or visit www.BCBSRI.com.

This Plan emphasizes preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You pay only the copayments, coinsurance, and deductibles described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

You should join a plan because you prefer the plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us.

We also have Point of Service (POS) benefits

Our plan offers POS benefits. This means you can receive covered services from a participating provider without a required referral, or from a non-participating provider. These out-of-network benefits have higher out-of-pocket costs than our in-network benefits.

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments or coinsurance. Blue Cross & Blue Shield of Rhode Island contracts with over 1,000 PCPs (family and general practitioners, internists, pediatricians, and some obstetrician/gynecologists who have chosen to participate as a PCP) and over 1700 specialists, along with a full range of hospitals across the State of Rhode Island and Southeastern Massachusetts. All participating PCPs practice out of offices in the community. Each member selects a primary care provider (PCP) who acts as a personal doctor working to coordinate all of your healthcare needs. When specialist services are needed, your PCP will refer you to a participating specialist. You must receive a referral from your PCP in order to receive maximum benefits.

We also have a POS product, which offers members the flexibility of obtaining services without a referral from their PCP or from non-Plan providers. You will be subject to deductibles and coinsurance. For more information regarding this benefit, see page 46.

- Your rights

Your medical and claims records are confidential

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies.

OPM requires that all FEHB Plans provide certain information to their FEHB members. You may get information about us, our networks, providers, and facilities. OPM's FEHB Web site (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- Years in existence: 68 years
- Profit status: Nonprofit

If you want more information about us, call (401) 274-3500. You may also contact us by fax at (401) 459-5089 or visit our Web site at www.BCBSRI.co m

Service Area

To enroll in this Plan, you must live in or work in our Service Area. This is where our providers practice. Our service area is the State of Rhode Island and the following cities and towns in the state of Massachusetts: Acushnet, Attleboro, Bellingham, Blackstone, Dartmouth, Dighton, Fall River, Fairhaven, Foxboro, Franklin, Mansfield, Medway, Mendon, Millville, New Bedford, North Attleboro, Norton, Plainville, Raynham, Rehoboth, Seekonk, Somerset, Swansea, Taunton, Uxbridge, Westport, and Wrentham.

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care benefits. We will not pay for any other healthcare services out of our service area unless the services have prior plan approval.

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. Blue Cross & Blue Shield of Rhode Island offers the HMO USA Guest Membership Program. To enroll in this program, please contact Customer Service at (401) 274-3500 from within Rhode Island or toll-free at 1-800-564-0888 from outside of Rhode Island. If you or a family member move, you do not have to wait until the Open Enrollment period to change plans. Contact your employment or retirement office.

Section 2 How we change for 2008

Do not rely on these change descriptions; this Section is not an official statement of benefits. For that, go to Section 5 Benefits. Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

Changes to this Plan

- United States Postal Service non-law enforcement career employees may now be covered either by Postal Category 1 or Postal Category 2 premium rates. See page 69.
- Your share of the non-Postal premium will increase for Self Only and increase for Self and Family. See page 69.

No benefit changes for 2008.

Section 3. How you get care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your electronic enrollment systems (such as Employee Express) confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at (401) 274-3500 from with in the State of Rhode Island or 1-800-564-0888 from outside of Rhode Island. You may also request replacement cards through our Web site at www.BCBSRI.com.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments, deductibles, and/or coinsurance, and you will not have to file claims. If you use our point-of-service program, you can also get care from non-Plan providers, or from participating providers without a required referral, but it will cost you more.

- **Plan providers**

Plan providers are physicians and other healthcare professionals in our service area that have signed agreement with us to provide covered services to our members. We credential Plan providers according to national standards.

We list Plan providers in the provider directory, which we update periodically. The list is also on our Web site, www.BCBSRI.com.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that have signed an agreement with us to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our Web site.

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care provider (PCP). This decision is important since your PCP provides or arranges for most of your healthcare. You will select a PCP for you and each covered member of your family when you enroll by completing the PCP selection care provided by the Plan. If you want to change your PCP at any time, you must contact Customer Service at (401) 274-3500 from within the State of Rhode Island and 1-800-564-0888 from outside of Rhode Island prior to receiving any services. The change will not be effective until the first day of the following month.

- **Primary care**

Your PCP can be a family practitioner, general practitioner, internist, or pediatrician. In addition, some OB/Gyns are also PCPs. Your PCP will provide most of your healthcare, or give you a referral to see a specialist.

If you want to change PCPs or if your PCP leaves the Plan, call us. We will help you select a new one.

- **Specialty care**

Your PCP will refer you to a specialist for needed care. When you receive a referral from your PCP, you must return to the PCP after the consultation, unless your PCP authorized a certain number of visits without additional referrals. The PCP must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your PCP gives you a referral. However, you may see your OB/GYN for annual exams, a Plan ophthalmologist or optometrist for your routine annual eye exam and receive up to twelve (12) chiropractic visits per year without a referral. In addition, you do not a referral from your PCP for mental health or substance abuse services, however you must receive authorization for these services from the Plan's mental health administrator.

Here are some other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your PCP will work with your specialist todevelop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your PCP will use our criteria when creating your treatment plan (the physician may have to get an authorization or approval beforehand).
- If you are seeing a specialist when you enroll in our Plan, talk to your PCP. Your PCP will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your PCP, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic and disabling condition and lose access to your specialist because we:

Terminate our contract with your specialist for other than cause; or

Drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program Plan; or

Reduce our service area and you enroll in another FEHB Plan.

You may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us, or if we drop out of the Program, contact your new plan.

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days

- **Hospital care**

Your Plan PCP or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our plan begins, call our Customer Service Department immediately at (401) 274-3500 from within Rhode Island or toll free at 1-800-564-0888 from outside of Rhode Island. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

If you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

- You are discharged, not merely moved to an alternative care center; or
- The day your benefits from your former plan run out; or
- The 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the FEHB Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such case, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

Circumstances beyond our control

Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necessary care.

• **Services requiring our prior approval**		Your PCP has authority to refer you for most services. For certain services, however, it is recommended that your physician obtain prior approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice. We call this review and approval process the Prospective Medical Review process. It is recommended that your physician obtain prior medical review for the following services to ensure that they will be covered: inpatient admissions, growth hormone therapy/home IV therapy, home physical, speech and occupational therapy, skilled nursing care, inpatient rehabilitation, surgical treatment of morbid obesity, outpatient mental health and substance abuse services require authorization from the Plan's Behavioral Health Administrator. Certain radiology services such as magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), computerized axial tomography (CAT or CT scans), positron emission tomography (PET scan), and nuclear cardiac imaging require authorization from the Plan's Radiology Program Administrator. You may be responsible for payment of these services if they are determined to not be medically necessary. We continue to recommend that you obtain prior medical review for these same services when utilizing the POS benefit. When utilizing non-Plan participating providers, it is recommended that you advise your provider to contact the Plan for prior medical review in advance of such services to ensure that they will be covered.

Section 4 Your costs for covered services

Copayments	A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive services. Example: When you see your PCP you pay a copayment of $15 per PCP office visit, $25 per specialist office visit, and when you go in the hospital, you pay $500 per admission.
Cost sharing	Cost sharing is the general term used to refer to your out-of pocket costs (e.g. deductible, coinsurance, and copayments) for the covered care you receive.
Deductible	A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. Copayments do not count toward any deductible. We do not have a deductible except as noted under the POS benefit.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance doesn't begin until you meet your deductible. Example: In our Plan, you pay 20% of our allowance for infertility services and durable medical equipment. Coinsurance also applies when you use the POS benefit.
Your catastrophic protection out-of-pocket maximum	After your in network inpatient copayments per admission reach $1,000 per person or $2,000 per family enrollment in any calendar year, you do not have to pay any more for covered inpatient services for that year. There are no other out-of-pocket maximums except as noted under the POS benefit. Be sure to keep accurate records of your copayments since you are responsible for informing us when you reach the maximum.
When Government facilities bill us	Facilities of the Department of Government Veteran Affairs, the Department of Defense and the Indian Health Services are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow.

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Section 5(a) Medical services and supplies provided by physicians and other health care professionals

Here are some important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We have no calendar year deductible for services received from participating Plan providers. Please see section 5 (i) regarding your Point-of-Service benefits.

Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay After the calendar year deductible…
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Diagnostic and treatment services	**High Option**
Professional services of physicians • In physician's office • At home • Office medical consultations • Second surgical opinion	$15 per visit to your primary care physician $25 per visit to a specialist
Professional services of physicians • In an urgent care center	$50 per visit
Professional services of physicians • During a hospital stay • In a skilled nursing facility	Nothing
Lab, X-ray and other diagnostic tests	**High Option**
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG	Nothing

Benefit Description	You pay After the calendar year deductible…
Preventive care, adult	**High Option**
Routine screenings, such as: • Total Blood Cholesterol – once every three years • Colorectal Cancer Screening, including • Fecal occult blood test • Sigmoidoscopy screening – every five years starting at age 50 • Double contrast barium enema – every five years starting at age 50 • Colonoscopy screening – every ten years starting at age 50 • Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older • Routine pap test Note: The office visit copay applies if test is received on the same day; see *Diagnosis and Treatment,* above.	Nothing
Routine mammogram – covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years	Nothing
Adult routine immunizations endorsed by Centers for Disease Control and Prevention (CDC): • Diphtheria, Tetanus, and Pertussis (Dtap) booster – once every 10 years, ages 19 to 64 (except as provided for under Childhood immunizations), • For ages 65 and older, Tetanus-Diptheria (Td) booster once every ten years. • Varicella (Chickenpox), ages 19 to 49 years • Influenza vaccine, annually • Pneumococcal vaccine, age 65 and older	Nothing
Not covered: Physical exams or immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges*

Benefit Description	You pay After the calendar year deductible…
Preventive care, children	**High Option**
• Childhood immunizations recommended by the American Academy of Pediatrics	Nothing
• Well-child care charges for routine examinations, immunizations and care (up to age 22) • Examinations, such as: - Eye exams through age 17 to determine the need for vision correction - Ear exams through age 17 to determine the need for hearing correction - Examinations done on the day of immunizations (up to age 22)	$15 per office visit
Not covered • *Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel.* • *Weight reduction programs, including laboratory tests related to programs designed for the purposes of weight reduction.* *Examination, evaluations, or services performed solely for educational or developmental purposes.*	*All charges*
Maternity care	**High Option**
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page 11 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. In addition, coverage of injury or illness or sickness including necessary care and treatment of medically diagnosed congenital defects and birth abnormalities will be covered for the first 31 days of a newborns life; all care after the first 31 days will be covered only if we cover the infant under a Self or Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision.	$15 for the initial office visit at Member's PCP, otherwise, $25 for initial office visit to Specialist; covered in full thereafter.

Maternity care - continued on next page

Benefit Description	You pay After the calendar year deductible…
Maternity care (cont.)	**High Option**
We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).	$15 for the initial office visit at Member's PCP, otherwise, $25 for initial office visit to Specialist; covered in full thereafter.
Not covered: *Routine sonograms to determine fetal age, size or sex.*	*All charges.*
Family planning	**High Option**
A range of voluntary family planning services, limited to: • Voluntary sterilization (See Surgical procedures Section 5 (b)) • Surgically implanted contraceptives • Diaphragms • Intrauterine devices (IUDs)	Nothing
• Injectable contraceptive drugs (such as Depo provera) Note: We cover oral contraceptives under the prescription drug benefit.	20%
Medically necessary genetic counseling	$25. per visit
Not covered: • *Reversal of voluntary surgical sterilization* • *Treatment for infertility when the cause of infertility was a previous sterilization.*	*All charges*
Infertility services	**High Option**
Diagnosis and treatment of infertility such as: • Artificial insemination: • intravaginal insemination (IVI) • intracervical insemination (ICI) • intrauterine insemination (IUI) • Assisted reproductive technology (ART) procedures, such as: • in vitro fertilization • embryo transfer, gamete GIFT, and zygote ZIFT • zygote transfer • Fertility drugs Note: We cover injectable fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit. Fertility drugs purchased at the pharmacy also have a 20% copayment.	20%

Infertility services - continued on next page

Benefit Description	You pay After the calendar year deductible…
Infertility services (cont.)	**High Option**
Not covered: • *Freezing (i.e., cryo-preservation) and storage of gametes, sperm, embryos or other specimens for future use;* • *Sperm bank (i.e., storage);* • *Cost of donor egg* • *Donor oocytes for non-infertile couples (e.g., member has genetic disorder, HIV + status, etc.);*	*All charges*
Allergy care	**High Option**
• Testing and treatment	$25 per office visit
• Allergy serum • Allergy injections	Nothing
Not covered: • *Provocative food testing* • *Sublingual allergy desensitization*	*All charges*
Treatment therapies	**High Option**
• Chemotherapy and radiation therapy Note: High-dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 30. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: Growth hormone is covered under the medical benefit. Note: Preauthorization is recommended for GHT treatment. Benefits for treatment will be continued as long as there has been a satisfactory response to growth hormone of at least 5cm a year after the first year. See Services requiring our prior approval in Section 3.	Nothing

Benefit Description	You pay After the calendar year deductible…
Physical and occupational therapies	**High Option**
Physical and occupational therapy for services by each of the following: • qualified physical therapists and • occupational therapists Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury. You must show significant improvement within sixty (60) days to receive authorization for additional treatment.	$25 per office visit $25 per outpatient visit Nothing per visit during covered inpatient admission
• Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to eighteen (18) weeks or thirty six (36) visits, which ever comes first.	Nothing
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs* • *Massage therapy* • *Recreation therapy*	*All charges*
Speech therapy	**High Option**
Speech therapy services by a speech therapist. Note: You must show significant improvement within sixty (60) days to receive authorization for additional treatment.	$25 per office visit $25 per outpatient visit Nothing per visit during covered inpatient admission.
Hearing services (testing, treatment, and supplies)	**High Option**
• First hearing aid and testing only when necessitated by accidental injury • Hearing testing for children through age 17, which include; (see *Preventive care, children)*	$25 per office visit
Not covered: • *All other hearing testing* • *Hearing aids, testing and examinations for them*	*All charges*

Benefit Description	You pay After the calendar year deductible…
Vision services (testing, treatment, and supplies)	**High Option**
One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts)	Nothing
• Annual eye refractions rendered by a Plan opthalmologist or optometrist Note: See Preventive care, children for eye exams for children.	$25 per office visit
Not covered: • *Eyeglassesor contact lenses and after age 17, examinations for them* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All charges*
Foot care	**High Option**
Foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. Note: See Orthopedic and prosthetic devices for information on podiatric shoe inserts.	$25 per office visit
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)* *All other routine foot care*	*All charges*
Orthopedic and prosthetic devices	**High Option**
• Artificial limbs and eyes; stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: See 5(b) for coverage of the surgery to insert the device. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.	$20 per item
Not covered:	*All charges*

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay After the calendar year deductible…
Orthopedic and prosthetic devices (cont.)	**High Option**
• *Orthopedic and corrective shoes* • *Arch supports* • *Foot orthotics* • *Heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices*	*All charges*
Durable medical equipment (DME)	**High Option**
Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover: • Hospital beds • Wheelchairs (the type of wheelchair we allow will depend on your medical condition) • Crutches • Walkers • Blood glucose monitors • Insulin pumps	$20 per item
• Diabetic supplies including test strips and lancets when from a participating DME supplier	20% copayment
Not covered: • *Equipment that serves as a comfort or convenience item. Electrical or mechanical features, which enhance basic equipment usually, serve a convenience function. Determination of medical necessity should be made regarding the coverage of these features.* • *Equipment used for environmental control or to enhance the environmental setting or surrounding of an individual should not e considered durable medical equipment. Examples of these include air conditioners, air filters, portable jacuzzi pumps, humidifiers, etc.* • *Repairs to patient owned equipment*	*All charges*

Benefit Description	You pay After the calendar year deductible…
Home health services	**High Option**
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications.	Nothing
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family;* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, orrehabilitative.*	*All charges*
Chiropractic	**High Option**
• Manipulation of the spine and extremities and extremities up to twelve (12) self-referred visits per calendar year • One set of x-rays of the spine every three (3) years	$25 per office visit
Not covered: *Other imaging studies or laboratory work ordered by a chiropractor*	*All charges*
Alternative treatments	**High Option**
No benefit.	All charges
Educational classes and programs	**High Option**
Coverage is limited to: • Smoking Cessation – Coverage is limited to primary care visits and individual counseling for smoking cessation. Note: Prescription nicotine substitutes, including transdermal patches, are covered under the prescription drug benefit up to a maximum of a three (3) month supply (see Section (5f)). Member must submit proof of being smoke free for a one-year period for reimbursement.	$15 per office visit
• Asthma self-management	Nothing
• Diabetes self-management – Diabetes education, when medically necessary and prescribed by a physician, may be provided only by the physician or, upon his or her referral to, an appropriately licensed and State certified diabetes educator.	$15 per office visit

Section 5(b) Surgical and anesthesia services provided by physicians and other health care professionals

Here are some important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We have no calendar year deductible for services received from participating Plan providers. Please see Section 5 (i) regarding your Point of Service benefits.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).

YOUR PHYSICIAN SHOULD GET PRIOR MEDICAL REVIEW OF SOME SURGICAL PROCEDURES. Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

Benefit Description	You pay After the calendar year deductible…
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Surgical procedures	**High Option**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see Reconstructive surgery) • Surgical treatment of morbid obesity (bariatric surgery). Note: The following medical criteria must be met for coverage: - Eligible members must be age 18 or over - BMI of 40 or BMI of 35 with significant comorbidities (e.g. cardiovascular including high blood pressure, diabetes, etc.) - documented failure of weight loss attempts - obesity present for at least 5 years - no untreated metabolic/endocrine abnormalities - Preauthorization is required	$25 per office visit; Nothing for surgery

Surgical procedures - continued on next page

Benefit Description	You pay After the calendar year deductible…
Surgical procedures (cont.)	**High Option**
• Insertion of internal prosthetic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefit for insertion of the pacemaker. • Voluntary sterilization (e.g., Tubal ligation, Vasectomy) • Treatment of burns	$25 per office visit; Nothing for surgery
Not covered: • *Reversal of voluntary sterilization* • *Blood Storage* • *Routine treatment of conditions of the foot; see Foot care*	*All charges*
Reconstructive surgery	**High Option**
Reconstructive surgery • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance of breasts; - treatment of any physical complications, such as lymphedemas; - breast prostheses and surgical bras and replacements (see Prosthetic devices) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	Nothing
Not covered:	*All charges*

Reconstructive surgery - continued on next page

Benefit Description	You pay After the calendar year deductible…
Reconstructive surgery (cont.)	**High Option**
• *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation*	*All charges*
Oral and maxillofacial surgery	**High Option**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures. • Medical or surgical treatment of Temporo-Mandibular Joint Disorder (TMJ)	Nothing
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* • *Dental treatment of TMJ*	*All charges*
Organ/tissue transplants	**High Option**
Solid Organ transplants limited to: • Cornea • Heart • Heart/lung • Kidney • Kidney/Pancreas • Liver • Lung: Single – Double • Pancreas • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	**High Option**
Blood or marrow stem cell transplants limited to the stages of the following diagnoses. The medical necessity limitation is considered satisfied if the patient meets the staging description. • Allogeneic (donor) bone marrow transplants for the following conditions: acute lymphomcytic (i.e., myelogenous) leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, chronic myelogenous leukemia, severe combined immunodeficiency, severe or very severe aplastic anemia, phagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors • Medications directly related to the transplant for a one-year period after the transplant **All transplants must be performed at a Plan-designated center of excellence.** Limited Benefits – Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in a National Cancer Institute – or National Institutes of Health-approved clinical trial at a Plan-designated center of excellence. Preauthorization is recommended. Note: We cover related medical and hospital expenses of the donor when we cover the recipient.	Nothing
• Transportation/lodging when performed at a Plan-designated center of excellence	Up to $5,000.
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*

Benefit Description	You pay After the calendar year deductible…
Anesthesia	**High Option**
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	Nothing

Section 5(c) Services provided by a hospital or other facility, and ambulance services

Here are some important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- We have no calendar year deductible for services received from participating Plan providers. Please see Section 5 (I) regarding your Point-of-Service benefits.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i. e., physicians, etc.) are in Sections 5(a) or (b).

YOUR PHYSICIAN MUST GET PRECERTIFICATION OF HOSPITAL STAYS. Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You pay
Note: The calendar year deductible applies only when we say below: "(calendar year deductible applies)".	
Inpatient hospital	**High Option**
Room and board, such as • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • Meals and special diets. Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	$500. per admission $1000 individual /$2000 family out-of-pocket maximum for admission copays per calendar year.
Other inpatient hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: calendar year deductible applies.)	Nothing
• Anesthetics, including nurse anesthetist services • Take-home items	Nothing

Inpatient hospital - continued on next page

Benefit Description	You pay
Inpatient hospital (cont.)	**High Option**
• Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: calendar year deductible applies.)	Nothing
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • Private nursing care	*All charges*
Outpatient hospital or ambulatory surgical center	**High Option**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service Note***:*** – We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	Nothing
Not covered: Blood and blood derivatives not replaced by the member	*All charges.*
Extended care benefits/Skilled nursing care facility benefits	**High Option**
Extended care/ Skilled nursing facility (SNF) benefit: • Bed, board and general nursing care • Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by a skilled nursing facility when prescribed by a Plan doctor.	Nothing
Not covered: Custodial care	*All charges.*

Benefit Description	You pay
Hospice care	**High Option**
• Supportive and palliative care for a terminally ill member is covered in the home or hospice facility • Family counseling • Hospice services are provided under the direction of Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six (6) months or less.	
• Inpatient care	$500 per admission $1000 individual/$2000 family out-of-pocket maximum per calendar year
• Outpatient care	*Nothing*
Not covered: Independent nursing, homemaker services	*All charges*
Ambulance	**High Option**
Local professional ambulance service when medically appropriate	Nothing
• Air and water ambulance are only covered when medically appropriate and provided in the United States and its territories	All charges over $3,000 per occurrence

Section 5(d) Emergency services/accidents

Here are some important things to keep in mind about these benefits:

Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.

- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

What to do in case of emergency:

Emergencies within our service area

Please call your PCP. In extreme emergencies, if you are unable to contact your doctor, call 911 or go to the nearest emergency room. Be sure to tell the emergency room personnel that you are a Plan member do they can notify the Plan. You or your family member should notify the Plan within 48 hours unless it is not reasonably possible to do so. It is your responsibility to ensure that the plan has been notified timely.

If you need to be hospitalized in a non-Plan facility, the Plan must be notified within forty-eight (48) hours or on the first working day following your admission, unless it is not reasonably possible to notify the Plan within that timeframe.

To be covered by this Plan, any follow-up care recommended by a non-Plan provider must be approved by a Plan provider except as covered under the POS benefit.

Emergencies outside our service area

Benefits are available for any medically necessary health service that is immediately required because of injury or unforeseen illness.

If you need to be hospitalized, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If a Plan doctor believed care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

To be covered by this Plan, any follow-up care recommended by a non-Plan provider must be approved by a Plan provider except as covered under the POS benefits.

Benefit Description	You pay After the calendar year deductible…
Emergency within our service area	**High Option**
• Emergency care at a doctor's office	$15 per PCP visit $25 per Specialist visit
• Emergency care at an urgent care center	$50 per visit
• Emergency care in an outpatient hospital facility, including doctors' services	$100 per visit. If emergency results in an admission to a hospital, the copay is waived.
Not covered: Elective care or non-emergency care	*All charges.*
Emergency outside our service area	**High Option**
• Emergency care at a doctor's office • • Emergency care at an urgent care center • • Emergency care as an outpatient at a hospital, including doctors' services Note: We waive the ER copay if you are admitted to the hospital.	$25 per visit $50 per visit $100 per visit.
Ambulance	**High Option**
Professional ambulance service when medically appropriate.	Nothing
Air and water ambulance are only covered when medically appropriate and provided in the United States and its territories Note: See 5(c) for non-emergency service.	*All Charges over $3,000 per occurrence*

Section 5(e) Mental health and substance abuse benefits

When you get our approval for services and follow a treatment plan we approve, cost-sharing and limitations for Plan mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The inpatient copayment applies to inpatient hospital and some alternative care settings
- Be sure to read Section 4, Your costs for covered services, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

YOU MUST GET PREAUTHORIZATION OF THESE SERVICES. See the instructions after the benefits description below.

Benefit Description	You pay After the calendar year deductible…
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Mental health and substance abuse benefits	**High Option**
All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost sharing responsibilities are no greater than for other illnesses or conditions.
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management	$25 per office visit
• Diagnostic tests • Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization.	Nothing $500 per admission $1000 individual /$2000 family out-of-pocket maximum per admission per calendar year
• Services in approved alternative care settings such as facility based intensive outpatient treatment, residential treatment	$25 per office visit
Not covered: • *Services not coordinated through our Administrator* • *Methadone treatment programs*	*All Charges.*

Mental health and substance abuse benefits - continued on next page

Benefit Description	You pay After the calendar year deductible…
Mental health and substance abuse benefits (cont.)	**High Option**
Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another **Preauthorization** To be eligible to receive these benefits you must obtain a treatment plan and follow all of the following network authorization processes: *Authorization of treatment for inpatient and intensive outpatient mental health conditions and substance abuse may be obtained directly by contacting our Behavioral Health Administrator at 800-544-5977 or 401-276-4052 prior to services being rendered. Our Administrator will determine and authorize the appropriate number of visits and determine the appropriate specialist. A referral from your PCP is not required.* **Limitation** We may limit your benefits if you do not obtain a treatment plan.	*All Charges.*

Preauthorization	To be eligible to receive these benefits you must obtain a treatment plan and follow all of the following network authorization processes:
Limitation	We may limit your benefits if you do not obtain a treatment plan.

Section 5(f) Prescription drug benefits

Here are some important things to keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We have no calendar year deductible.

Be sure to read Section 4, Your costs for covered services, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

There are important features you should be aware of. These include:

- **Who can write your prescription.** A licensed physician must write the prescription.
- **Where you can obtain them.** You may fill the prescription at a Plan pharmacy. Most prescription drugs are available though the participating mail-order pharmacy. Contact Customer Service at 401-274-3500 from within the State of Rhode Island or 800-564-0888 from outside of Rhode Island for more information or to obtain a mail service enrollment form directly log on to www.BCBSRI.org.
- **We use a formulary.** Blue Cross & Blue Shield of Rhode Island uses a drug formulary, which is a listing of quality, cost effective medications that are covered under you prescription drug benefit for a lower copay. We cover non-formulary drugs prescribed by a physician; however, you will be responsible for a higher copay.
- **These are the dispensing limitations.** Prescription drugs prescribed by a physician will be dispensed for up to a 30-day supply for non-maintenance drugs and maintenance drugs. If there is no generic equivalent available, you will still have to pay the brand name copayment. A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand or if you specifically ask and sign for a brand name medication.

Plan members called to active military duty (or members in time of national emergency) who need to obtain prescribed medications should call our Members Services Department at 800-564-0888.

- **A generic equivalent will be dispensed if it is available**, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the brand name copayment. Also if there is no generic equivalent available, you will have to pay the brand name copayment.
- **Why use generic drugs?** Generic drugs are lower-priced drugs that are the therapeutic equivalent to more expensive brand-name drugs. They must contain the same active ingredients and must be equivalent in strength and dosage to the original brand-name product. Generics cost less than the equivalent brand-name product. The U.S. Food and Drug Administration sets quality standards for generic drugs to ensure that these drugs meet the same standards of quality and strength as brand-name drugs. You can save money by using generic drugs. However, you and your physician have the option to request a name brand if a generic option is available. Using the most cost-effective medication saves money.
- **When you do have to file a claim.** You will be required to submit a claim for prescriptions purchased from a non-Plan pharmacy. You will be required to pay the non-Plan pharmacy directly and the Plan will reimburse you once you have submitted the receipt, your name, Plan identification number to Basic Claims Administration, 444 Westminster Street, Providence, RI 02903.

Benefit Description	You pay After the calendar year deductible…
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Covered medications and supplies	**High Option**
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered.* • Insulin • Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction (contact Customer Service for limitations) • Contraceptive drugs and devices purchased at the pharmacy • Injectable drugs purchased at the pharmacy • Prenatal vitamins	$7 per prescription unit or refill for generic drugs $30 per prescription unit or refill for brand name drugs on the Plan's formulary $50 per prescription unit or refill for brand name drugs not listed on the Plan's formulary Mail order: $14 for formulary generic; $60 for formulary brand drugs; $100 for non-formulary drugs for a 90-day supply Note: If there is no generic equivalent available, you will still have to pay the brand name copay. In addition, if a brand name drug becomes available as a generic, you will be required to pay the highest copayment.
Diabetic supplies, including test strips and lancets purchased at the pharmacy	20% copayment
Fertility drugs purchased at the pharmacy	20% copayment
• *Not covered:* • *Over-the-counter drugs (Even if prescribed)* • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Compound medications not made up of at least one Legend drug* • *Vitamins (excluding prenatal), nutrients and food supplements even if a physician prescribes or administers them* • *Drugs and supplies for the purpose of weight reduction* • *Nonprescription medicines*	*All charges*

Section 5(g) Special features

Under the flexible benefits option, we determine the most effective way to provide services.

- We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit.
- Alternative benefits are subject to our ongoing review.
- By approving an alternative benefit, we cannot guarantee you will get it in the future.
- The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits.
- Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.

For the deaf or hearing impaired, please call our TDD Number. From outside Rhode Island dial 1-888-252-5051 and from within the State of Rhode Island dial (401) 459-5505.

When you or a covered member are traveling throughout the United States, and need urgent medical care before you return home, call 800-810-BLUE to locate a Blue Cross & Blue Shield traditional provider or log on to www.bcbs.com. In addition, you must contact Customer Service before or after you receive care (within 48 hours) to ensure that your claim is paid appropriately. Please remember to coordinate all follow-up care through your PCP.

If you are pregnant, you will be part of our Little Steps prenatal program. Little Steps is designed to work with you and your physician to help you have the healthiest baby possible. Little Steps includes free classes on parenting, newborn care and breast-feeding. The classes are held at participating hospitals throughout Rhode Island. For more information contact Customer Service.

To ensure you receive quality care, we selectively choose medical facilities that specialize in various transplants to participate in our network. The facilities are chosen based on the duration of their transplant program, volume of transplants performed each year, patient outcomes, and qualifications of their transplant program medical staff. Each facility is well known and respected throughout the country, and is designated a “Center of Excellence” for its commitment to quality care and positive patient outcomes. By utilizing one of our network facilities, you will receive quality care and can better manage your costs. For more information, contact Customer Service.

Section 5(h) Dental benefits

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary
- Plan dentists must provide or arrange your care.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Desription	You Pay
Accidental injury benefit	**High Option**
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury caused by an unexpected or unintentional means and services are received within seventy-two (72) hours of injury.	$100 per hospital emergency room visit
Only the following services are covered: • Extraction of teeth needed to avoid infection of teeth damaged in the injury • Suturing and suture removal • Re-implanting and stabilization of dislodged teeth • Medication received from the provider	$25 per office visit
Not covered: Injuries incurred as a result of biting and/or chewing	*All charges*
Dental benefits	**High Option**
We have no other dental benefits.	*All charges*

Dental Benefits	You Pay
Service	**High Option**
Office visits	$xx

Section 5(i) Point of Service benefits

Point of Service (POS) Benefits

Facts about this Plan's POS option

At your option, you may choose to obtain benefits covered by this Plan from non-Plan doctors and hospitals whenever you need care, except for the benefits listed below under "What is not covered." Benefits not covered under Point of Service must either be received from or arranged by Plan doctors to be covered. When you obtain covered non-emergency medical treatment from a non-Plan doctor without a referral from a Plan doctor, you are subject to the deductibles, coinsurance and maximum benefit stated below.

What is covered

Under the point-of-service benefit, you are covered for medically necessary, covered health services when you self-refer to a non-Plan provider or to a Blue Cross & Blue Shield of Rhode Island provider without a referral from your PCP. You may receive medically necessary covered health services listed in this brochure, except for services listed under what is not covered. Once you use the point-of –service benefit, all services associated with the episode of care (i.e., lab, x-ray, hospitalization) will be paid according to your point-of –services benefit. If you choose to use the point-of-services benefit, you will receive a lower allowance than when the standard benefit is utilized.

You are able to self-refer to non-Plan provider either inside or outside of our service area. You must call Blue Cross & Blue Shield of Rhode Island for authorization for hospitalization.

Plan Authorization

When utilizing the POS benefit, we continue to recommend that you obtain prior medical review for the same services that we recommend you do so under the Standard benefit. When utilizing non-Plan participating providers, it is recommended that you advise your provider to contact the Plan for prior medical review in advance of such services to ensure they will be covered.

Deductible

When the point-of-service benefit is utilized, you pay a $500 deductible per member per calendar year or a $1000 deductible per family per calendar year for doctor's visits, other outpatient services, and hospital services. The deductible is not reimbursable by the Plan. If you decide to use non-Plan providers or self refer to a Plan provider, this deductible applies to all covered benefits. Copayments under the Blue Cross & Blue Shield of Rhode Island's point-of-service benefit cannot be used to meet your calendar year deductible.

Coinsurance

Members are able to self-refer to a provider either inside or outside the Service Area. If the self-referral is to a provider who does not participate with the BlueCHiP network, but who is part of the Blue Cross & Blue Shield national traditional network (Host Blue), you will only be responsible for your deductible and the 30% coinsurance. To check if the provider participates with this program, please call 1-800-810-BLUE or log on to www.bcbs.com. These providers will file the claim directly. This feature is referred to as the BlueCard program.

If you self-refer to a provider who is neither part of the BlueCHiP network, nor part of the BlueCard program, you will be responsible for any amount over our allowance, in addition to your deductible and coinsurance amount.

When you use the Flex Plan Rider to self-refer for services to participating provider, BCBSRI will pay 70% of our fee schedule based on existing contractual relationships with the provider. BlueCHiP providers cannot charge the member more than the contracted fee.

When you obtain health care services through the BlueCard program outside the BlueCHiP network, you will pay 30% of the amount for the covered services. The amount charged for a covered service is calculated on the lower of:

- The billed charges for your Covered Health Care Services, or
- The negotiated price that the on-site Blue Cross &/or Blue Shield Plan ("Host Blue") passes on to us.

Often, this "negotiated price" will consist of a simple discount, which reflects the actual price paid by the Host Blue. However, sometimes it is an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an average expected savings with your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating your liability for covered services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate your liability calculation methods that differ from the usual BlueCard method noted above in this section or require a surcharge, We would then calculate your liability for any Covered Health Care Services in accordance with the applicable state statute in effect at the time you received your care.

When you receive services from providers that are not contracted with BlueCHiP or a Host Blue Plan, we will pay 70% of the fee schedule, as determined by BlueCHiP. The member is responsible for the remaining balance of the non-network provider's charges if they are greater than the fee schedule. Payment for these services will be made directly to the member. The member is responsible to pay the provider directly for the services.

All payments made by BlueCHiP for services through the Point of Service benefit will be subject to a deductible as outlined above.

Out-of-Pocket Maximum

You are protected by an out-of-pocket maximum of $5,000 per person per calendar year and $10,000 per family per calendar year. This includes deductibles and copayments. Charges over the fee allowance cannot be applied to the out-of-pocket maximum.

Emergency Benefits

True, medically necessary emergency care (even if received from a non-participating provider) is always covered as a standard benefit.**What is Not Covered**

- Anesthesia consultations
- Chiropractic care
- Diagnostic procedures, such as laboratory tests and x-rays
- Durable Medical Equipment (DME) and medical supplies
- Emergency room visits
- Home health services
- Infertility services
- Mental conditions/substance abuse benefits
- Outpatient physical, speech and occupational therapies, cardiac rehabilitation
- Rehabilitation hospitalizations
- Skilled nursing facility care
- Transplant coverage
- Vision care benefits

How to Obtain Benefits

If you receive services from a non-participating provider, you may be required to pay up front and submit to us for reimbursement. Please call Customer Service at 401-274-3500 from within the State of Rhode Island or toll free at 1-800-564-0888 from outside of Rhode Island for a claim form. We will provide you with a form within 15 days of your request. Submit the claim to Basic Claims Administration, 444 Westminster Street, Providence, RI 02903 as soon as possible. You must submit a complete claim form by December 31 of the year after the year you received the service. Either OPM or we can extend this deadline if you show that circumstances beyond your control prevented you from filing on time.

Section 5 (j) Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file an FEHB disputed claim about them.** Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums.

Medicare prepaid plan

Enrollment

This Plan offers Medicare recipients the opportunity to enroll in the Plan through Medicare. As indicated on page 48, annuitants and former spouses with FEHBP coverage and Medicare Part B may elect to drop their FEHBP coverage and enroll in a Medicare prepaid plan when one is available in their area. They may then later re-enroll in the FEHBP Program. Most federal annuitants have Medicare Part A. Those without Medicare Part A may join this Medicare prepaid plan but will probably have to pay for hospital coverage in addition to the Part B premium. Before you join the plan, ask whether the plan covers hospital benefits and, if so, what you will have to pay. Contact your retirement system for information on dropping your FEHBP enrollment and changing to a Medicare prepaid plan. Contact us at 1-800-505-2583 for information on the Medicare prepaid plan and the cost of that enrollment.

If you are Medicare eligible and are interested in enrolling in a Medicare HMO sponsored by this Plan without dropping your enrollment in this Plan's FEHB plan, call 1-800-505-2583 for information on the benefits available under the Medicare HMO.

Section 6 General exclusions – things we don't cover

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition an we agree, as discussed under *What Services Require Our Prior Approval* on page 12.**

We do not cover the following:

- Care by non-plan providers except for authorized referrals or emergencies (see *Emergency services/accidents*);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or ;
- Services, drugs, or supplies related to sex transformations;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program; or
- Services, drugs, or supplies you receive without charge while in active military service.

Section 7 Filing a claim for covered services

When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment, coinsurance, or deductible. You will only need to file a claim when you receive emergency services from non-plan providers. Sometimes these providers bill us directly. Check with the provider. If you need to file the claim, here is the process:

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Your facility will file on the UB-92 form. For claims questions and assistance, call us at 401-274-3500 from within the State of Rhode Island or toll-free at 800-564-0888 from outside of Rhode Island.

When you must file a claim – such as for services you receive outside the Plan's service area – submit it on the HCFA-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member's name and ID number;
- Name and address of the physician or facility that provided the service or supply;
- Dates you received the services or supplies;
- Diagnosis;
- Type of each service or supply;
- The charge for each service or supply;
- A copy of the explanation of benefits, payments, or denial from any primary payer – such as the Medicare Summary Notice (MSN); and
- Receipts, if you paid for your services.

Submit your claims to: *Basic Claims Administration, 444 Westminster Street, Providence, Rhode Island02903*

Deadline for filing your claim

Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny benefits for your claim if you do not respond.

Section 8 The disputed claims process

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for preauthorization/prior approval:

1 Ask us in writing to reconsider our initial decision. You must:

a) Write to us within 6 months from the date of our decision; and

b) Send your request to us at:*444 Westminster Street, Providence, Rhode Island02903*and

c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and

d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.

2 We have 30 days from the date we receive your request to:

a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or

b) Write to you and maintain our denial - go to step 4; or

c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.

3 You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have.

We will write to you with our decision.

4 If you do not agree with our decision, you may ask OPM to review it.

You must write to OPM within:

- 90 days after the date of our letter upholding our initial decision; or
- 120 days after you first wrote to us - if we did not answer that request in some way within 30 days; or
- 120 days after we asked for additional information.

Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 3, 1900 E Street, NW, Washington, DC 20415-3630.

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.

Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

5 OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals.

If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

You may not sue until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and

a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 401-274-3500 from with in the State of Rhode Island or toll-free at 800-564-0888 from outside Rhode Island and we will expedite our review; or

b) We denied your initial request for care or preauthorization/prior approval, then:

- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
- You may call OPM's Health Insurance Group 3 at 202-606-0737 between 8 a.m. and 5 p.m. eastern time.

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and

a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at xxx and we will expedite our review; or

b) We denied your initial request for care or preauthorization/prior approval, then:

- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
- You may call OPM's Health Insurance Group x at 202/606-xxxx between 8 a.m. and 5 p.m. eastern time.

Section 9 Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you or a covered family member have coverage under another group health plan or have automobile insurance that pays health care expenses without regard to fault. This is called "double coverage".

When you have double coverage, one plan normally pays its benefits in full as the primary payer and the other plan pays a reduced benefit as the secondary payer. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' guidelines.

When we are the primary payer, we will pay the benefits described in this brochure.

When we are the secondary payer, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance.

What is Medicare?

Medicare is a Health Insurance Program for:

- People 65 years of age or older.
- Some people with disabilities under 65 years of age.
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (Someone who was a Federal employee on January 1, 1983 or since automatically qualifies.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.

Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare's Low-Income Benfits. For people with limited inco9me and resources, extra help in paying for a Medicare prescription durg plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

- **Should I enroll in Medicare?**

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age65. It's easy. Just call the Social Security Administration toll-free number 1-800-772-1213 to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage. It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan.

- **The Original Medicare Plan (Part A or Part B)**

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care. Your care must continue to be authorized by your PCP, or precerified as required.

Claims process when you have the Original Medicare Plan – You probably will never have to file a claim form when you have both our Plan and the Original Medicare Plan.

When we are the primary payer, we process the claim first.

When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claim, call us at 401-274-3500 from within Rhode Island or toll-free at 800-564-0888 from outside of Rhode Island or see our Web site at www.BCBSRI.com.

We do not waive any costs if the Original Medicare Plan is your primary payer.

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contract Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov.

If you enroll in a Medicare Advantage plan, the following options are available to you:

This Plan and our Medicare Advantage plan: You may enroll in our Medicare Advantage plan and also remain enrolled in our FEHB plan.In this case, we do not waive cost sharing for your FEHB coverage.

This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers), but we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area.

- **Medicare prescription drug coverage (Part D)**

When we are the primary payer, we process the claim first. If you enroll in Medicare Part D and we are the secondary payer, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

Medicare always makes the final determination as to whether they are the primary payer. The following chart illustrates whether Medicare or this Plan should be the primary payer for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly.

Primary Payer Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payer for the individual with Medicare is...**	
	Medicare	**This Plan**
1) Have FEHB coverage on your own as an active employee or through your spouse who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #1 above	✓	
4) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and... • You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
5) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #1 above	✓	
6) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
7) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty	✓ *	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and • It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD (30-month coordination period)		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and • This Plan was the primary payer before eligibility due to ESRD		✓ for 30-month coordination period
• Medicare was the primary payer before eligibility due to ESRD	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

*Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

TRICARE and CHAMPVA	TRICARE is the health care program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. IF TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs. **Suspended FEHB coverage to enroll in TRICARE or CHAMPVA**: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under TRICARE or CHAMPVA.
Workers' Compensation	We do not cover services that: You need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws. Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care.
Medicaid	When you have this Plan and Medicaid, we pay first. **Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance:** If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the State program.
When other Government agencies are responsible for your care	We do not cover services and supplies when a local, State, or Federal government agency directly or indirectly pays for them.
When others are responsible for injuries	When you receive money to compensate you for medical or hospital care for injuries or illness caused by another person, you must reimburse us for any expenses we paid. However, we will cover the cost of treatment that exceeds the amount you received in the settlement. If you do not seek damages you must agree to let us try. This is called subrogation. If you need more information, contact us for our subrogation procedures.
When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage	Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com, you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Section 10 Definitions of terms we use in this brochure

Calendar year	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 13.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 13.
Covered services	Care we provide benefits for, as described in this brochure.
Deductible	A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 13.
Experimental or investigational service	Experimental or investigational services include any treatment procedure, facility, equipment, drug, device, supply or service when the service has progressed to limited human application, but has not been recognized as proven effective in clinical medicine. A service is considered experimental or investigational if the Plan determines that one or more of the following circumstances are true: 1) the service is the subject of an ongoing clinical trial or is under study to determine the maximum tolerated dose, toxicity, safety, efficacy, or efficacy as compared with a standard means of treatment or diagnosis; or 2) the prevailing opinion among experts regarding the service is that further studies or clinical trials are necessary; or 3) the current belief in the pertinent specialty of the medical profession in the United States is that the service or supply should not be used for the diagnosis or indications being requested outside of clinical trials or other research settings because it requires further evaluation for that diagnosis or indications.
Group health coverage	A plan maintained by an employer to provide medical care, directly or indirectly, to employees, ex-employees and their families
Medical necessity	Medical necessity means the health care services provided to treat your illness or injury. The services must: 1) be essential to the diagnosis, treatment, or care of your condition; 2) be commonly and customarily recognized in your provider's profession as appropriate for you diagnosis; 3) be performed in the most cost-effective manner or at a location providing a less intensive level of care; and 4) not be determined by us to be experimental or investigational.
Plan allowance	Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways. We determine our allowance as follows: (a) the amount the provider charges for the service or (b) the maximum amount we pay any provider for that service
Us/We	Us and We refer to *Blue Cross & Blue Shield of Rhode Island (BCBSRI)*
You	You refers to the enrollee and each covered family member.

Coverage information

No pre-existing condition limitation

We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.

Where you can get information about enrolling in the FEHB Program

See www.opm.gov/insure/health for enrollment information as well as:

- Information on the FEHB Program and plans available to you.
- A health plan comparison tool
- A list of agencies who participate in Employee Express
- Information on and links to other electronic enrollment systems

Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Benefits,* brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

- When you may change your enrollment;
- How you can cover your family members;
- What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire;
- When your enrollment ends; and
- When the next open season for enrollment begins.

We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office.

Types of coverage available for you and your family

Self-Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your unmarried dependent children under age 22, including any foster children or stepchildren your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 22 years of age or older who is incapable of self-support.

If you have a Self-Only enrollment, you may change to a Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately when family members are added or lose coverage for any reason, including your marriage, divorce, annulment, or when your child under age 22 turns age 22 or has a change in marital status.

If you or one of your family members is enrolled in one FEHB plan, that person may not be enrolled in or covered as a family member by another FEHB plan.

Children's Equity Act

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self and Family coverage in the FEHB Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll for Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross & Blue Shield Service Benefit Plan's Basic Option;
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross & Blue Shield Service Plan's Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children. If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that doesn't serve the area in which your children live as long as the court/administrative order is in effect. Contact your employing office for further information.

When benefits and premiums start

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2007 benefits of your old plan or option**. However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

When you retire

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage (TCC).

When you lose benefits

When FEHB coverage ends

You will receive an additional 31 days of coverage, for no additional premium, when:

- Your enrollment ends, unless you cancel your enrollment, or
- You are a family member no longer eligible for coverage.

Any person covered under the 31 day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the plan during the continuance of the confinement but not beyond the 60th day after the end of the 31 day temporary extension.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC), or a conversion policy (a non-FEHB individual policy.)

Upon divorce

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage to you. But, you may be eligible for your own FEHB coverage under the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide To Federal Benefits,* or other information about your coverage choices. You can also download the guide from OPM's Web site, www.opm.gov/insure.

Temporary Continuation of Coverage (TCC)

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal job, if you are a covered dependent child and you turn 22 or marry, etc.

You may not elect TCC if you are fired from your Federal job due to gross misconduct.

Enrolling in TCC. Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Benefits,* from your employing or retirement office or from www.opm.gov/insure. It explains what you have to do to enroll.

Converting to individual coverage

You may convert to a non-FEHB individual policy if:

- Your coverage under TCC or the spouse equity law ends (If you canceled your coverage or did not pay your premium, you cannot convert);
- You decided not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

If you leave Federal service, your employing office will notify you of your right to convert. You must apply in writing to us within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will **not** notify you. You must apply in writing to us within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, and we will not impose a waiting period or limit your coverage due to pre-existing conditions.

Getting a Certificate of Group Health Plan Coverage

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other healthcare coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

For more information, get OPM pamphlet RI 79-27, *Temporary Continuation of Coverage (TCC) under the FEHB Program.* See also the FEHB Web site at www.opm.gov/insure/health; refer to the "TCC and HIPAA" frequently asked questions. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and information about Federal and State agencies you can contact for more information.

Section 12 Three Federal Programs complement FEHB benefits

Important information

OPM wants to make sure you are aware of three Federal programs that complement the FEHB Program.

First, the **Federal Long-Term Care Insurance Program (FLTCIP)** helps cover long term care costs, which are not covered under the FEHB Program.

Second, the **Federal Flexible Spending Account Program**, also known as **FSAFEDS**, lets you set aside pre-tax money to pay for health and dependent care expenses. The result can be a discount of 20% to more than 40% on services you routinely pay for out-of-pocket.

Third, the new **Federal Employees Dental and Vision Insurance Program (FEDVIP)** provides comprehensive dental and vision insurance at competitive group rates. There are several plans from which to choose. Under **FEDVIP** you may choose self only, self plus one, or self and family coverage for yourself and any qualified dependents.

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection

The Federal Long-Term Care Insurance Program (FLTCIP) can help you pay for the potentially high cost of long term care services, which are not covered by FEHB plans. Long-term care help you receive to perform activities of daily living, such as bathing or dressing yourself, or supervision you receive because of a severe cognitive impairment. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). To request an Information Kit and application, call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

The Federal Flexible Spending Account Program - *FSAFEDS*

What is an FSA?

It is a tax-favored benefit that allows you to set aside pre-tax money from your paychecks to pay for a variety of eligible expenses. Annuitants are not eligible to enroll.

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of $250 and a maximum annual election of $5,000.

- **Healthcare FSA (HCFSA)** – Pays for eligible healthcare expenses for you and your dependents which are not covered or reimbursed by FEHB coverage or other insurance.
- **Limited Expense Healthcare FSA (LEX HCFSA)** – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your dependents, which are not covered or reimbursed by FEHBP or FEDVIP coverage or other insurance.
- **Dependent Care FSA (DCFSA) –** Pays for eligible dependent care expenses that allow you (and your spouse if married) to work, look for work (as long as you have earned income for the year), or attend school full-time.

Where can I get more information about FSAFEDS?

Visit www.FSAFEDS.com **or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, 9 a.m. until 9 p.m. Eastern Time. TTY: 1-800-952-0450.**

The Federal Empolyees Dental and Vision Insurance Program – *FEDVIP*

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is a program, separate and different from the FEHB Program, established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004. This program has no pre-existing condition limitations. FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Premiums are withheld from salary on a pre-tax basis.

Dental Insurance

Dental Plans provide a comprehensive range of services, including the following:

- Class A (Basic) services, which include oral examinations, prophylaxis diagnostic evaluations, sealants, and X-rays.
- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges, and prosthodontic services such as complete dentures.
- Class D (Orthodontic) services with a 24-month waiting period.

Vision Insurance

Vision plans provide comprehensive eye examinations and coverage for lenses, frames, and contact lenses. Other benefits such as discounts on LASIK surgery may also be available.

Additional Information

You can find a comparison of the plans available and their premiums on the OPM Web site at www.opm.gov/insure/dentalvision. This site also provides links to each plan's Web site where you can view detailed information about benefits and preferred providers.

How do I enroll?

You enroll on the internet at www.BENEFEDS.com. For those without access to a computer, call 1-877-888-FEDS (TTY number, 1-877-TTY-5680). If you do not have access to a computer or a phone, contact your employing office or retirement system for guidance on how to enroll.

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Do not rely on this page; it is for your convenience and may not show all pages where the terms appear.

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Summary of Benefits for Blue Cross & Blue Shield of Rhode Island - 2008

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

Standard Option Benefits	You Pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Office visit copay: $15 primary care; $25 specialist	
Services provided by a hospital:		
• Inpatient	$500 per admission copay	
• Outpatient	Nothing	
Emergency benefits:		
	$100 per emergency room visit; $50 per urgent care center visit; $15 per primary care office visit; $25 per specialists office visit	
Mental health and substance abuse treatment:	Regular cost sharing	
Prescription drugs:	$7 for formulary generic drugs; $30 for formulary brand drugs; $50 for non-formulary drugs at a participating pharmacy for each 30-day supply	
Dental care:	No benefit.	
Vision care: • Annual Eye Exam • Eyeglasses	$25 per office visit Nothing for one pair of eyeglasses to correct impairment directly caused by intraocular surgery; No other benefit for eyeglasses	
Special features: *Reciprocity Benefit; High Risk Pregnancy*		
Point of Service benefits: – Yes		xx
Protection against catastrophic costs (out-of-pocket maximum)**:**	Nothing for in-network inpatient admissions after $1000 per person/$2000 per family per calendar year Some costs do not count toward this protection	

2008 Rate Information for Blue Cross & Blue Shield of Rhode Island

Non-Postal rates apply to most non-Postal employees. If you are in a special enrollment category, refer to the *Guide to Federal Benefits* for that category or contact the agency that maintains your health benefits enrollment.

Postal Category 1 rates apply to certain career non-law enforcement Postal Service employees. **Postal Category 2 rates** apply to other career non-law enforcement Postal Service employees. *PostalEASE*, the employee self-service system used for FEHB enrollment, automatically provides the applicable premium to individual employees. Career non-law enforcement employees may also refer to the *Guide to Federal Benefits for United States Postal Service Employees*, RI 70-2, to determine their rates.

Different rates apply and a special Guide is published for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

For further assistance, Postal Service employees should call:

Human Resources Shared Service Center, 1-877-477-3273, Option 5, TTY: 1-866-260-7507

Postal rates do not apply to non-career postal employees, postal retirees, or associate members of any postal employee organization who are not career postal employees. Refer to the applicable *Guide to Federal Benefits*.

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	Category 1 Your Share	Category 2 Your Share